MY CSHCS PLAN OF CARE – PART A

DATE PLAN DEVELOPED:

NAME:	PLAN OF CARE COMPLETED ☐ FACE TO FACE ☐ IN HOME ☐ OVER PHONE
AKA:	ETHNICITY ☐ African American ☐ American Indian ☐ Asian ☐ Hispanic ☐ White Non-Hispanic ☐ Other
M ☐ F ☐ DOB:	
ADDRESS:	CITY: ZIP:
TEL #	CSHCS ELIG DATES:
ALTERNATIVE TEL #	CO CODE: CO NAME:
RECIPIENT ID#:	
CHILD LIVES WITH ☐ Biological Family ☐ Extended Family ☐ Adoptive Family ☐ Foster Family ☐ Blended Family ☐ Other Explain	
PARENTS/GURADIANS:	
Comments:	
PRIMARY CARE GIVER:	
PRIMARY CARE GIVER SPEAKS: IS: ☐NON-VERBAL ☐ DEAF ☐ BLIND	TRANSLATOR NAME/CONTACT INFO:
EMERGENCY CONTACT/BACK UP CAREGIVER:	PHONE: RELATIONSHIP:
EMERGENCY PLAN IN PLACE☐ YES ☐ NO	TURNING 21 IN 12 MONTHS OR LESS ☐ YES ☐ NO
Would you like assistance to put one together? ☐ YES☐ NO	Would you like assistance with the transition? ☐ YES ☐ NO

CARE COORDINATOR:	TEL #:

MY INSURANCE INFORMATION

INSURANCE NAME:	Insurance Type Med ☐ Rx ☐ Dental ☐ Vision ☐	ID#	TEL#
POLICY HOLDER:	Primary ☐ Secondary ☐	CASEWORKER:	TEL#

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